MELANIE MASSEY PHYSICAL THERAPY

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Our mission: To joyfully use our gifts to brighten the lives of others.

Pediatric Patient History Questionnaire

PATIENT AND FAMILY INFORMATION

Patient's name: _____ Preferred name: _____
DOB: _____ / _____ / _____ Age: _____ Gender: ☐ M ☐ F

Please check if your child has difficulty in any of the following areas.

☐ Gross motor ☐ Reading ☐ Speech ☐ Walking
☐ Fine motor ☐ Self-help ☐ Swallowing ☐ Weakness
☐ Handwriting ☐ Sensory ☐ Vision ☐ Other: _____

Is the patient being seen in any pain? ☐ Yes ☐ No Explain: _____

Has your child ever received therapy for the same concerns? ☐ PT ☐ OT ☐ST When? _____

What are your goals for therapy? _____
_____

CHILD'S MEDICAL HISTORY

Please check all that apply.

☐ ADD/ADHD ☐ Fetal Alcohol Syndrome ☐ Oppositional Defiant Disorder
☐ Apraxia of speech ☐ Learning Disability ☐ Seizure Disorder*
☐ Autism (ASD) ☐ Muscular Dystrophy ☐ Stuttering
☐ Chromosomal Abnormality ☐ Obsessive Compulsive Disorder ☐ Traumatic Brain Injury
☐ Cytomegalovirus ☐ Other: _____

(*) Seizure Disorder, if yes, are seizures controlled by medications? ☐ Yes ☐ No
Describe how the seizures present and any precautions we need to take. _____
_____

Does your child require any of the following?

☐ G or GJ tube* ☐ Oxygen* ☐ Ventilator *
(*) MMPT is NOT responsible for trach or feeding needs

Allergies? ☐ Yes ☐ No If yes, please specify: _____
Medications? ☐ Yes ☐ No If yes, please specify medications below.

Medication Name	Purpose	Prescribing Physician

Medical Procedures:

Specify any procedures your child has undergone:

☐ EEG ☐ Swallow study ☐ VP shunt placement
☐ MRI/CT scan/x-ray ☐ Surgery ☐ Other: _____

Specialty Physicians:

Specify any physicians your child sees.

☐ Cardiology ☐ Gastroenterology ☐ Neurosurgery ☐ Pulmonology
☐ ENT ☐ Neurology ☐ Orthopedics ☐ Other: _____

Adaptive Equipment or Assistive Devices:
Has your child ever required any of the following?
☐ AFOs ☐ Hand splints ☐ Standing frame
☐ Communication device ☐ Shoe inserts ☐ Walker/gait trainer

Hearing:
Does your child's hearing appear normal? ☐ Yes ☐ No
Does your child have frequent ear infections? ☐ Yes ☐ No Ear tubes? ☐ Yes ☐ No
If yes, at what age(s) did your child receive the tubes? _____ Are tubes still in place? ☐ Yes ☐ No
Was a hearing test REPEATED? ☐ Yes ☐ No Age(s): _____
Is there a diagnosed hearing impairment? ☐ Yes ☐ No Specify: _____
Does your child wear hearing aids or have cochlear implants? ☐ Yes ☐ No Specify: _____

Vision:
Does your child have visual problems? ☐ Yes ☐ No If yes, what is the diagnosis?_____
Does your child have prescription glasses? ☐ Yes ☐ No Are glasses worn? ☐ Yes ☐ No

Educational Information:
Child's school/daycare: _____ Grade:_____ Any grades repeated: ☐ Yes ☐ No

Services provided through the school system or Early Steps:
☐ APE ☐ PT ☐ Reading Intervention
☐ OT ☐ ST ☐ Special Education/Instructor

PREGNANCY & BIRTH HISTORY:

Pregnancy & Delivery Period
Length of Pregnancy: _____ (in weeks)

Is the child a twin? ☐ Yes ☐ No In case of twins is the other child well? ☐ Yes ☐ No

Please indicate any complications during pregnancy.
☐ High blood pressure ☐ Preeclampsia ☐ Other:_____
☐ Placenta detachment ☐ Sepsis

Was alcohol consumed during pregnancy? ☐ Yes ☐ No
Were illicit drugs consumed during pregnancy? ☐ Yes ☐ No

Did any problems arise during fetal development? ☐ Yes ☐ No Please explain: _____
Were there any complications during labor? ☐ Yes ☐ No Please explain: _____

Type of delivery (check all that apply):
☐ Vaginal ☐ Forceps ☐ Planned C-Section
☐ Induced ☐ Vacuum ☐ Emergency C-Section

Immediately After Birth
Child's Birth Weight: _____ (lbs. oz.) Child's Birth Length: _____
Did the child aspirate (swallow) meconium? ☐ Yes ☐ No
Was child placed on oxygen? ☐ Yes ☐ No How long? _____ (days)
Was child placed on respirator? ☐ Yes ☐ No How long? _____ (days)
Was child placed in NICU? ☐ Yes ☐ No How long? _____ (days)

Early Months Feeding & Swallowing
Does your baby breastfeed? ☐ Yes ☐ No
Does your baby have difficulty latching onto the nipple? ☐ Yes ☐ No
Is there a preferred feeding side? ☐ Yes ☐ No Specify: _____

Does your baby bottle feed? ☐ Yes ☐ No
Does your baby have difficulty latching onto the bottle? ☐ Yes ☐ No

Does the child experience reflux? ☐ Yes ☐ No
If yes, was medication prescribed? ☐ Yes ☐ No Specify: _____

Did anyone ever say that your child aspirated food/liquid at any time? ☐ Yes ☐ No
If yes, please explain: _____

DEVELOPMENTAL MILESTONES

Gross Motor:

Were the following developmental milestones achieved?
Rolling ☐ Yes ☐ No Age: _____ Crawling ☐ Yes ☐ No Age: _____ Walking ☐ Yes ☐ No Age: _____
Sitting ☐ Yes ☐ No Age: _____ Standing ☐ Yes ☐ No Age: _____

Please indicate if your child has difficulty with any of the following.

☐ Jumping	☐ Running	☐ Walking
☐ Going up and down stairs	☐ Skipping	☐ Other: _____

Please describe any concerns with the way your child walks: _____

Does your child fall often? ☐ Yes ☐ No
Do you consider your child clumsy? ☐ Yes ☐ No

Sensory:

Does your child display any of the following behaviors?

☐ Avoids touching textures	☐ Dislikes textured clothing or seams
☐ Difficulty self-soothing	☐ Dislikes walking barefoot over various surfaces
☐ Dislikes position changes (such as bath time and diaper changes)	☐ Easily distracted/frustrated
	☐ Fear of heights
☐ Dislikes loud noises	☐ Fidgety/touches everything
☐ Dislikes grooming/hygiene tasks	☐ Picky eater

Behavior:

Do you believe that your child has behavioral problems? ☐ Yes ☐ No ☐ Not sure
If yes, do you consider them to be: ☐ Mild ☐ Moderate ☐ Severe

Which of the following behaviors does your child display to himself or others?

☐ Biting	☐ Hitting	☐ Temper tantrums
☐ Head banging	☐ Staring spells	☐ Other: _____

Self-Help:

Can your child independently drink from a cup? ☐ Yes ☐ No
Which feeding utensils can your child use independently?

☐ Spoon	☐ Fork	☐ Knife

Which of the following clothing items can your child put on independently?

☐ Belt	☐ Pants/shorts	☐ Socks
☐ Shirt	☐ Shoes	☐ Undergarments

Can your child tie his/her own shoes? ☐ Yes ☐ No

Which of the following can your child manipulate independently?

☐ Buttons	☐ Snaps	☐ Zippers

Handwriting:

Hand dominance: ☐ Left ☐ Right ☐ Not yet established
Do you notice your child swapping hands while completing schoolwork? ☐ Yes ☐ No
Do you notice your child propping or resting his head on the table during writing tasks? ☐ Yes ☐ No
Does your child complain of hand fatigue/pain during writing tasks? ☐ Yes ☐ No

Reading:
Does your child lose his place when reading? ☐ Yes ☐ No
Does your child use his finger as a guide when reading to avoid losing his place? ☐ Yes ☐ No
Does your child move his head/neck left to right when reading rather than only using his eyes? ☐ Yes ☐ No

Play Skills:
Does your child purposefully play with toys appropriate for his/her age? ☐ Yes ☐ No
What does your child like to play with? _____ Dislike playing with? _____

Speech and Language:
How does the child usually communicate? ☐ Gestures ☐ Single Words ☐ Short Phrases ☐ Sentences
How much of your child's speech can you understand?
☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100%
Approximately how many words does your child consistently use?_____

Please check if your child has difficulty with any of the following skills.
☐ Following spoken directions
☐ Responding to his/her name
☐ Repeating what you say
☐ Making verbal requests
☐ Answering "who", "what", "where" questions
☐ Naming colors
☐ Identifying 5 body parts
☐ Using pronouns

	Age	Example
Babbling		
First words		
Putting 2 words together		
Putting 3-4 words together		
Sentences		

In your own words, describe your child's speech/language problem: _____
_____
Please give two to three examples of your child's comments that are typical at this time:_____
_____

Swallowing – Eating – Drinking:
Swallowing and feeding problems come in various forms. Please share with us any problems listed below that you have observed with your child during mealtimes.

Feeding Behaviors and Problems to Resolve	Always	Often	Sometimes	Never
Aspirations/"colds" while drinking/eating				
Coughing while drinking/eating				
Drooling				
Food/drink spillage from mouth				
Gagging				
Nasal discharge while eating/drinking				
Spitting out food				
Sticking tongue out				
Vomiting				
Other:				

Is your child on a special diet? ☐ Yes ☐ No If yes, be specific: _____
Does your child often refuse to eat? ☐ Yes ☐ No

Agreement:
I hereby certify that the above statements are true and correct to the best of my knowledge.
Patient/Guardian Signature: _____ Date: _____ / _____ / _____
Patient/Guardian Print: _____